

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY — DIVISION OF PENSIONS AND BENEFITS**Alternate Benefit Program
Application for Transfer
(INTRA-FUND)**

This application must be completed by all Alternate Benefit Program participants transferring locations and continuing their Alternate Benefit Program participation.

PART I: To be completed by the employee. (Please Print)

I, _____, ABP Membership No.: _____
(ASSIGNED BY DIVISION OF PENSIONS AND BENEFITS)

resigned my position as _____ at _____

on the _____ day of _____, 20 _____. I hereby notify the Division of Pensions and Benefits that I have accepted employment at _____ and request that the Division continue my participation in the Alternate Benefit Program at this new location.

IMPORTANT: *Any change which you wish to make in beneficiaries or in TIAA/CREF deductions must be made on the appropriate change forms which may be obtained from your benefits officer. If you had a Salary-Reduction Agreement with your former employer and wish to continue the reduction, you must sign a new agreement with your new employer.*

PART II: To be completed by your new employer.

1. Employee's Title: _____

2. Appointment Date: _____

3. Full-Time Employee: ☐ Yes ☐ No

4. Employed: ☐ Ten ☐ Twelve Months

5. Social Security No.: _____

6. Annual Base Salary: \$ _____

7. Location or Payroll No.: _____

I certify that this employee is a full-time permanent employee eligible under the rules and regulations of the Department of Higher Education, for participation in the Alternate Benefit Program.

SIGNATURE OF CERTIFYING OFFICER

TITLE